STATE OF MINNESOTA OFFICE OF ADMINISTRATIVE HEARINGS FOR THE COMMISSIONER OF HEALTH

In the Matter of Janesville Nursing Home, Survey Completed 7/15/2004 RECOMMENDED DECISION

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Beverly Jones Heydinger on Monday, October 11, 2004, at 9:30 a.m. at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, MN 55401. The meeting concluded on that date.

Appearances: Marci Martinson and Mary Cahill, Division of Facility and Provider Compliance, Department of Health, 1645 Energy Drive, Suite 300, St. Paul, MN 55108-2970. Peter Madel III and Kelly Breck, 102 East North Street, Janesville, MN 56408, Janesville Nursing Home.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made, and for the reasons set out in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

- 1. That citation F-241 be reduced to Level "A";
- 2. That citation F-272 be affirmed;
- 3. That citation F-280 be affirmed in part, and dismissed in part;
- 4. That citation F-328 be affirmed;
- 5. That citation F-444 be reduced to Level "A";
- 6. That citation F-465 be reduced to Level "A".

Dated this 18th day of October, 2004.

s/Beverly Jones Heydinger
BEVERLY JONES HEYDINGER
Administrative Law Judge

Recorded: Tape-recorded (One Tape, No Transcript Prepared)

MEMORANDUM

<u>Citation F-241</u> – Respect for the dignity of a patient.

The guidance for surveyors states that activities should be carried out by staff in a manner that assists the resident to maintain and enhance self-esteem and self-worth. In particular, it includes "[r]especting resident's social status, speaking respectfully,...treating residents with respect." The surveyor was in a hallway of the nursing home and overheard two staff calling to each other about whether Resident #2 had been toileted. The facility disputes that the exchange was loud or inappropriate, and that the staff was sharing information so that the resident received the necessary care. There is some dispute about the distance separating the two staff, how loud the exchange was, and whether the visitor heard the exchange. However, the surveyor heard the exchange and was not part of the conversation. Thus, any third person could have heard the exchange. It was disrespectful of the resident's privacy to have the conversation where persons not participating in the resident's care could hear it.

This deficiency was classified at level D, an isolated deficiency with no actual harm but the potential for more than minimal harm. There was no evidence that an isolated incident of this type has the potential for "more than minimal" harm. Only repeated incidents carry that risk. Thus it is recommended that the scope and severity be reduced to Level "A".

Citation F-272 - Resident Assessment.

The facility must conduct a comprehensive assessment of each resident using an assessment instrument established by the Department. The Minimum Data Set (MDS) is the established assessment instrument. It must include information from the resident assessment protocols (RAPS) in several areas, including continence. The Department's position is that the information in the MDS and the RAPS must take into account observation of the resident, interviews with staff, and review of the resident's records, facility policies and procedures in order to comprehensively assess the bladder function of the

residents, and the resident's record should document how that information was collected so that it can be compared with the continence care plan. The facility disagrees. It maintains that it completed the RAPS and the MDS, that those constitute the required assessment, and additional documentation is not required.

The Department found two instances where it did not believe that there was consistency between the care plan and the care given, and that the discrepancy could be traced to an inadequate assessment of when the resident needed to be toileted. In particular, the "Urinary Continence and Incontinence Policy" stated that each resident should be assessed annually. There was no indication that Residents #2 and #3 had the annual assessment. For Resident #2 and Resident #3, the plan was to toilet/change the resident before and after breakfast, lunch and supper, at bedtime and on night rounds. A note in the resident's file indicated that a bladder assessment was completed for Resident #2 on August 6, 2002, but the facility did not provide a document that showed the information collected about bladder function, medication, toileting behavior including urinary frequency, or an assessment of the resident's cognitive and physical abilities. In addition, the staff was following a plan to toilet the resident Mr. Madel noted during the conference that the plan's every two hours. reference to toileting before and after meals was easier to comply with than a two-hour plan. Ms. Breck noted that the nursing assistants would report changes in the resident's patterns, if changes occurred. Since many residents do not change, in her view there is no need to periodically redo the assessment.

The Facility's policy was to have a 48-hour data collection at admission, and an annual reassessment. There was no documentation that the data concerning frequency of urination or toileting behavior had been annually reviewed and documented, as set forth in the policy. Thus, it is recommended that the citation be upheld.

Citation F-280 – Revision of the Care Plan.

The facility was cited for two situations where the surveyor believed that the care plan did not accurately reflect the status of the resident. The facility must provide necessary care to services "to attain or maintain the highest practicable physical, mental and psychosocial well-being," in accordance with the care plan and assessments. The surveyors will check to see if the care plan is revised if the resident's status has changed.

For Resident #7, the care plan stated that a personal alarm should be hooked to the resident when she was is in bed, but it was not attached to her. The personal alarm signals to the staff that a resident is attempting to get out of bed without assistance, and, in this case, the alarm's purpose was to prevent the resident from falling. When the deviation from the care plan was pointed out to the facility staff, the staff changed the care plan.

For Resident #2, the care plan included motion therapy three times a week from nursing rehabilitation. At the time of the survey, the facility did not have a rehabilitation aide and other staff was performing the therapy. However, the care plan had not been updated to reflect the staff responsible for the therapy.

The Facility maintains that a care plan must be updated periodically, and that it is not required to immediately amend the care plan each time there is a change. For Resident #7, the alarm was no longer needed, and the resident was able to remove it herself. The care plan had been revised two weeks prior to the survey, but it was not clear whether the resident was still at risk of falling. For Resident #2, the Facility maintained that there had been no change in the care, but only in the staff assigned to perform it. In its view, this was not a significant change of status, and did not require an immediate change to the care plan. The care plan was scheduled for revision on July 29, 2004.

The Department's position is that a resident should not have to wait for the next scheduled revision of the care plan if a need changes. It does not require a new MDS (absent a "significant change," as defined), but only a revision to the care plan.

Since the Facility had failed to document that Resident #7 was no longer at risk of falling, and the care plan was designed to prevent falls, the Department has shown that this citation should be upheld. Simply removing the requirement of the alarm from the care plan did not adequately address the resident's needs. However, the citation for Resident #2 should be dismissed. There was no evidence that the needs of the resident had changed, or that she was not receiving the appropriate range of motion assistance. It is likely that the surveyors could have verified in the resident's chart if the therapy was in fact received. The care plan was due for a review shortly after the survey. Thus, there is no indication that the care plan was inadequate or would interfere with the resident receiving the highest practicable level of care.

Since this citation was classified as "isolated," the scope and severity level D is still appropriate.

Citation F-328 – Proper respiratory treatment and care.

Resident #3's baseline oxygen saturation was between 90% and 96% from December 2003 through May 2004. At the time of the quarterly review on 12/16/03, the MDS indicated that the resident had short-term memory loss and no indicators of delirium or periodic disordered thinking or awareness. The annual MDS was reviewed on 3/9/04, and a quarterly review completed on 6/1/04. These indicated that the resident was exhibiting periods of altered perception or awareness/surroundings. Resident #3's care plan stated that she would receive a mini-mental exam as needed for changes in cognition.

On 5/21/04, the resident informed the nursing assistant that she thought horses had run by the window. The oxygen saturation on that date was recorded at 86%. The level was measured at 84% on 6/1/04. Staff did not assess the resident's respiratory status, did not place the resident on oxygen, and did not complete a mini mental assessment. Staff reported to the surveyor that the resident frequently sees livestock, but that was not reflected in the resident's MDS. Staff told the surveyors that oxygen was administered when the oxygen saturation level decreased, but did not have a particular level that triggered it. They relied on the resident's baseline, and familiarity with the resident.

The facility states that the nurses used their judgment to assess the resident who was not exhibiting any signs or symptoms of hypoxia, and no immediate action was required. Instead, the staff would look for a trend that might indicate a problem if it occurred in conjunction with other symptoms. It is also apparent from the charting that in each instance, the oxygen saturation went above 90% at the next scheduled reading.

In light of the resident's diagnoses, and the care plan directive to follow up on changes of oxygen saturation, the citation is upheld. Although the facility's policy was to measure oxygen more frequently when the level decreased, it did not do so. Similarly, the quarterly MDS reflected periods of altered perception or awareness/surroundings, but the mini mental assessment called for in the treatment plan was not administered.

Resident #10 was hospitalized with pneumonia on May 21, 2004, and a doctor's order written to maintain oxygen saturation at 93% or above. It is not apparent how long the doctor intended for the higher level to remain in effect, however on June 2 and 3, the oxygen level fell to 78, and there is no evidence that steps were taken to raise the oxygen level. The documentation of the level on June 1 is unclear. Later in the month, the level also dropped, but it is not clear if the prior standing order to maintain the level at about 90% was back in effect at that time. Overall, it appears that the facility was monitoring the oxygen levels carefully and could easily discern a drop. Nonetheless, the lowered levels in early June, without evidence of supplemental oxygen, support the citation.

Citation F-444 – Infection Control

In one instance, a staff member contaminated her gloves with feces while attending to a resident, and then touched the strap on a mechanical lift sling in the resident's room prior to removing the gloves and washing her hands. However the Department's information about the percentage of times the Facility's hand washing policy was violated is confusing. The Department observed 6 different residents receiving personal cares, but it is not clear if it observed only one care per resident or more. Thus, it is difficult to evaluate the validity of the Department's position that the policy was violated greater than 15% of the time. The Department did not enlarge the number of observations after it

viewed this occurrence, and the small number (1 out of 6) yields a misleading result.

It is understood that staff must always wash their hands after coming into contact with body secretions or excretions. However, the Facility pointed out that it had the proper policies and procedures in place, and that this observation occurred only one time over four days, involving only one staff person. The Facility also pointed out that the straps on the lift are used by only one patient and are laundered at the end of the day. According to the Facility, the staff member continued to work with the same patient, and then properly removed the gloves and washed. Based on the information provided, there was no evidence of potential for more than minimal harm. Thus, it is recommended that the scope and severity should be at Level "A".

<u>Citation F-465</u> – Other Environmental Conditions

A facility must provide a safe, functional, sanitary and comfortable environment. During the survey the Department noticed that four doors were gouged, and there was some buildup of dirt along the baseshoe on the floor near the nurses' desk and by the public water fountain. The Department assigned a Level B deficiency, that is, in substantial compliance, and with potential for no more than minimal harm. The facility objects to being cited for the deficiency at all.

The applicable rule states: "The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program." The Facility's position is that only 4 out of 92 doors were gouged, and that it checks the doors regularly, and makes repairs as required. It submitted a door repair schedule showing two door repairs in August and three in September. Its view is that perfection is not required. As for the baseshoe, its position is that the baseshoe is old and discolored, but it is not dirty. After the hearing, the Facility submitted its Monthly Maintenance checklist, but neither the doors nor the floors or baseshoe are included on it. It also submitted minutes from monthly safety committee meetings where staff may raise physical plant problems. Although this is an appropriate forum for raising issues, it does not assure that items such as the doors and floors are regularly checked.

This was a minor violation. If the Facility had been able to document that the doors or baseshoe were regularly checked, and that they had in fact been checked prior to the Survey, it would be appropriate to dismiss the citation. Absent that evidence, it should be affirmed. However, it is not clear why this was classified at Level B rather than Level A. There was no evidence of a "pattern" since only maintenance staff was involved, and the identified problems occurred

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¹ Minn. R. 4658.1415, subp. 2.

only in a very limited number of locations. The evidence supports only the scope and severity Level "A".

B.J.H.